HEALTHCARE ON THE SQUARE

P.O. Box 540, Boydton, VA 23917
Phone: (434) 738-6102, Fax: (434) 738-6982

SLIDING FEE APPLICATION

Last Name	First Name	MI	Account #

Date of Birth	Social Security Number	Home Telephone	Work/Alt Telephone

Address:		State	Zip

Number of Persons in Household	Household Member	Social Security Number	Date of Birth
________			

Insurance Information:
What type of insurance do you have? ___ Medicaid ___ Medicare ___ Other: ______________________________

Yourself:
Employer: ____
Pay Cycle: ____ Weekly ____ Bi-Weekly ____ Monthly ____ Other: ___________________________________

Spouse/Other:
Employer: ____
Pay Cycle: ____ Weekly ____ Bi-Weekly ____ Monthly ____ Other: ___________________________________

Income Information:

Social Security	Child Support	SSI	Military Allotment	Disability	TANF
$	$	$	$	$	$
Pension/Retirement	Scholarship/Grant	Wages	Unemployment	Interest	Rental Income
$	$	$	$	$	$
Alimony	Dividends	Worker's Compensation		Net Business Income	
$	$	$		$	

I hereby certify that the above information is true. The only I have is stated above. I understand that this application will be reviewed annually and proof of income is required annually. I understand that if I give false information, withhold information, or fail to report in my income, that I could prosecuted for perjury, larceny, and/or fraud.

____ ___________________________
Signature **Date**

FOR OFFICE PERSONNEL ONLY

Total Annual Income: ____ SF Type: _________________________________
Interviewer: ____ Date: _________________________________

APPLICATION MUST INCLUDE ALL HOUSEHOLD MEMBERS AND PROOF OF ALL HOUSEHOLD INCOME TO PROCESS!